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(Title page)

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State of Connecticut
REGULATION
of

NAME OF AGENCY
Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION
Person-Centered Medical Home (PCMH) Program[1]

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-926 to 17b-262-936, inclusive, as follows:

(NEW) Sec. 17b-262-926. Purpose and Scope

Sections 17b-262-926 to 17b-262-936, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for provider participation in the Person-Centered Medical Home (PCMH) program, as authorized pursuant to sections 17b-3, 17b-262 and 17b-263c of the Connecticut General Statutes. The PCMH program provides technical assistance and, when applicable, additional payments to eligible primary care practices and providers that meet the criteria set forth in sections 17b-262-926 to 17b-262-936, inclusive, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-927. Definitions

As used in sections 17b-262-926 to 17b-262-936, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Advance per member payment" means a monthly or quarterly payment made prospectively to a practice with PCMH status or Glide Path status for care coordination and other expanded primary care services for patient office visits and other care settings pursuant to section 17b-262-932(d) of the Regulations of Connecticut State Agencies;

(2) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes and practicing within the APRN's scope of practice under state law;

(3) "APRN group" means a practice run by and comprised of more than one APRN;

(4) "Attending physician" means a physician who has primary responsibility for the treatment and care of a patient;

(5) "Children's Health Insurance Program" or "CHIP" means the federally subsidized program of health care for uninsured, low-income children authorized by Title XXI of the Social Security Act and operated by the department pursuant to sections 17b-289 to 17b-307, inclusive, of the

[1] **Draft Regulation**: Version attached to response to public comments, March 25, 2014.

Connecticut General Statutes, also known as HUSKY B;

(6) "Commissioner" means the Commissioner of Social Services or the commissioner's designee;

(7) "Community preceptor" means a physician who supervises one or more residents who provide care to patients at a practice or PCMH accreditation provider other than the community preceptor's primary practice location;

(8) "Connecticut Medical Assistance Program" or "CMAP" means all of the medical assistance programs administered by the department pursuant to state and federal law, including, but not limited to Medicaid and CHIP;

(9) "Current procedural terminology codes" or "CPT codes" means the procedural coding system established by the American Medical Association and modified by the United States Department of Health and Human Services or such other procedural coding system that the department currently requires providers to use when submitting CMAP claims, in accordance with 45 CFR 162.1002;

(10) "Day" means a calendar day;

(11) "Department" means the Department of Social Services or its agent;

(12) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT services" means the services provided in accordance with 42 USC 1396a(a)(43), 42 USC 1396d(a)(4)(B), 42 USC 1396d(r), 42 CFR 441, Subpart B and section 17b-261(i) of the Connecticut General Statutes;

(13) "Electronic health record" or "EHR" means a systematic collection of electronic health information on individual patients in a digital format that meets applicable PCMH standards for acceptable EHR systems and includes a range of data in comprehensive or summary form, such as: Demographics; medical history; medication; medication allergies; immunization status; laboratory test results; radiology images; vital signs; and personal statistics such as age, weight and billing information;

(14) "Enhanced fee-for-service payment" means a payment made to a practice with PCMH status or Glide Path status in addition to the regular FFS fee schedule, visit rate or other applicable amount for a service pursuant to section 17b-262-932(c) of the Regulations of Connecticut State Agencies, also known as a rate add-on;

(15) "Federally qualified health center" or "FQHC" has the same meaning as provided in 42 USC 1396d(*l*);

(16) "Fee-for-service" or "FFS" means a service delivery system with a cost-and-payment methodology for services provided to members;

(17) "Glide Path" means the process by which a practice not yet qualified, but seeking PCMH status, may receive initial financial and technical support from the department to assist the practice in qualifying for PCMH status pursuant to section 17b-262-929 of the Regulations of Connecticut State Agencies;

(18) "Independent physician group" means a physician-led practice that is (1) comprised of at least one physician and one or more additional primary care providers and (2) separately enrolled with the department as a physician group;

(19) "Individual APRN" means a practice comprised of only one APRN;

(20) "International Classification of Diseases" or "ICD" means the system of disease classification established by the World Health Organization and maintained and distributed by the United States Department of Health and Human Services or such other disease classification system that the department currently requires providers to use when submitting CMAP claims, in accordance with 45 CFR 162.1002;

(21) "Measurement year" means the calendar year immediately prior to the department's annual calculation of performance-based supplemental payments;

(22) "Medicaid" means the program authorized by Title XIX of the Social Security Act and operated by the department pursuant to section 17b-261 of the Connecticut General Statutes;

(23) "Member" means an individual eligible to receive goods or services under CMAP;

(24) "Non-standard practice" means a practice setting that is: (A) Staffed by one or more primary care providers; (B) licensed as a separate health care facility by the Department of Public Health; (C) (i) for a practice seeking or that has obtained PCMH status, not eligible for PCMH Level 2 or PCMH Level 3 recognition or (ii) for a PCMH accreditation provider, not eligible, as applicable, for PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition; and (D) determined by the department to provide primary care services consistent with the goals and purposes of the PCMH program;

(25) "Parent entity" means a provider that owns, operates or consists of one or more full-service practices and one or more satellite practices;

(26) "Patient panel" means a set of patients for whom a primary care provider is responsible for providing primary care services;

(27) "PCMH accreditation" means the department's process for approving a PCMH accreditation provider that meets a high standard of person-centered primary care pursuant to section 17b-262-930 of the Regulations of Connecticut State Agencies;

(28) "PCMH accreditation provider" means an FQHC or outpatient hospital clinic that seeks or has obtained PCMH accreditation pursuant to section 17b-262-930 of the Regulations of Connecticut State Agencies;

(29) "PCMH accreditation standard-setting authority" means one or more recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to a PCMH accreditation provider, such as The Joint Commission (TJC), which provides certification for TJC's Primary Care Medical Home program as part of the Ambulatory Health Care accreditation program, or the department as a standard-setting authority for PCMH accreditation;

(30) "PCMH Level 1" means the first level of PCMH primary care quality standards and certification established by the PCMH status standard-setting authority;

(31) "PCMH Level 2" means the second level of PCMH primary care quality standards and certification established by the PCMH status standard-setting authority;

(32) "PCMH Level 3" means the third level of PCMH primary care quality standards and certification established by the PCMH status standard-setting authority;

(33) "PCMH status" means the department's approval of a practice that meets a high standard of person-centered primary care pursuant to section 17b-262-928 of the Regulations of Connecticut State Agencies;

(34) "PCMH status standard-setting authority" means one or more recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to practices seeking or maintaining PCMH status, such as the National Committee for Quality Assurance (NCQA), which provides recognition as part of NCQA's Patient Centered Medical Home Program, or the department as a standard-setting authority for PCMH status;

(35) "PCMH survey tool scores" means scores associated with standards and elements of care as evaluated by the practice and submitted to the PCMH status standard-setting authority or the PCMH accreditation standard-setting authority, as applicable, based on the practice's self-assessment of its ability to meet applicable PCMH standards and elements;

(36) "Performance-based supplemental payment" means a supplemental payment based on performance pursuant to section 17b-262-933 of the Regulations of Connecticut State Agencies;

(37) "Person-centered medical home" or "PCMH" means a provider that provides high quality, person-centered primary care services in accordance with standards selected by the department;

(38) "Physician" means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes and acting within the physician's scope of practice under state law;

(39) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes and acting within the physician assistant's scope of practice under state law;

(40) "Practice" means an individual practice site that provides predominantly primary care services and: (A) Is an independent physician group, solo physician, APRN group, individual APRN, outpatient hospital clinic or a non-standard practice that is a satellite entity of one or more of the other practice settings set forth in this subparagraph; (B) is enrolled in CMAP with a valid provider enrollment agreement on file with the department; (C) maintains all required licenses from the Department of Public Health; and (D) provides primary care services by or under the direction of one or more primary care providers;

(41) "Primary care provider" means a physician, APRN or physician assistant who: (A) Provides general pediatric, internal medicine, family practice or geriatric primary care services to a patient at the point of first contact; (B) takes continuing responsibility for providing the

patient's care; and (C) has an active, unrestricted license from the Department of Public Health;

(42) "Primary care services" means preventive health services, health maintenance, treatment of illness and injuries and ongoing management of chronic conditions provided by a primary care provider;

(43) "Provider" means an individual or entity that furnishes goods or services pursuant to a valid CMAP provider enrollment agreement with the department;

(44) "Quality measures" means written quality performance standards for practices established by the department to calculate performance-based supplemental payments, which may include separate sets of measures for pediatric and adult patient populations;

(45) "Resident" means an individual participating in an internship or residency program or United States medical officer candidate training program pursuant to a permit issued by the Department of Public Health for such purpose in accordance with section 20-11a of the Connecticut General Statutes;

(46) "Solo physician" means a practice comprised of only one physician;

(47) "Technical assistance" means non-financial support from the department to assist a provider in obtaining or maintaining PCMH status or PCMH accreditation, including assistance provided as part of Glide Path; and

(48) "Visit rate" means a flat rate that is all-inclusive per visit for services provided by an outpatient hospital clinic.

(NEW) Sec. 17b-262-928. Requirements for PCMH Status

(a) In order to qualify for and maintain PCMH status, a practice shall, at the time it submits its PCMH status application, and on an ongoing basis:

(1) Be enrolled in CMAP with a valid provider enrollment agreement on file with the department and comply with all CMAP policies and procedures;

(2) Comply with all unique PCMH billing requirements, as required by the department;

(3) Achieve and maintain PCMH Level 2 or PCMH Level 3 recognition, except that the department may, in its discretion, deem a non-standard practice to meet the requirements of this subdivision if the non-standard practice demonstrates that: (A) It provides care in accordance with a written schedule of service hours that it submits to the department for approval as part of its PCMH status application and resubmits to the department for re-approval not less than fourteen days before it proposes to change such schedule; (B) it is a satellite practice of a parent entity that achieved and maintains (i) PCMH Level 2 or PCMH Level 3 recognition and (ii) PCMH status approval from the department pursuant to this section; (C) it follows the same policies and procedures as the parent entity, including, but not limited to, using the same electronic health record system; (D) on behalf of the non-standard practice, its parent entity will provide access to care or health care advice at one or more of the parent

entity's full-service practices that achieved and maintains PCMH status approval from the department, on days and hours when the non-standard practice does not provide care, seven days per week, twelve months per year; and (E) it will provide additional information in its claims for payment as required by the department;

(4) Use an electronic health record system for all patients treated within the practice and ensure that such records are available to, and shared by, all clinicians in the practice, as appropriate. Such system shall support both clinical and administrative functions including, but not limited to: Scheduling; treating patients; ordering services; prescribing; maintaining medical records; population management; and follow-up;

(5) Comply with EPSDT services requirements, including, but not limited to: Timely comprehensive well visits, including hearing and vision screening; timely developmental screening; referral for preventive dental care for appropriate age groups; and referral for follow-up care based on conditions identified in well visits and inter-periodic visits and screenings;

(6) Participate in the department's primary care initiatives, as directed by the department;

(7) Participate in initiatives to improve health equity including, but not limited to: Participating in educational forums; collecting and analyzing data to review disparities related to race and ethnicity; and engaging in efforts to act on data-driven opportunities for improvements that reduce such disparities;

(8) Adhere to consumer protections, including, but not limited to: Ensuring members' rights to confidentiality; nondiscrimination; timely access; informed choice; participation in treatment decisions; and access to a grievance process;

(9) Provide the department with access to the practice's staff, facilities and documents involved in seeking and maintaining PCMH status, including, but not limited to copies of reports, tools and other documents from the PCMH status standard-setting authority;

(10) Allow the department to include the practice on lists of PCMH providers available to members and referral sources; and

(11) Comply with all written department policies, which the department shall publicize to all practices with PCMH status and Glide Path status and practices that have applied for such status before such policies take effect. The department shall post such policies on its website or by other means accessible to practices.

(b) PCMH Status Effective Date.

(1) The effective date of a practice's PCMH status is the later of: (A) The first day of the month in which the practice submits a complete PCMH application to the department, (B) the first day of the month after the practice receives PCMH Level 2 or PCMH Level 3 recognition, as applicable, and notifies the department in writing with evidence of such recognition or (C) January 1, 2012.

(2) A practice shall not receive any PCMH-related payments before the effective date of

PCMH status or any payments based on: (A) Claims with dates of service before the effective date of PCMH status or (B) member enrollment months attributed to the practice before the effective date of PCMH status.

(c) Each practice shall provide the department with a list of all primary care providers for whom it seeks PCMH-related payments and shall send the department any changes to such list not more than thirty days after any change occurs. Each such primary care provider shall, at the time the practice submits its PCMH application and on an ongoing basis:

(1) Be enrolled with CMAP as an individual provider with a valid provider enrollment agreement on file with the department;

(2) Have a primary professional affiliation with the practice, except as provided in subdivision (3)(B) of this subsection;

(3) Function as a primary care provider and have a patient panel, except that:

(A) An APRN working in collaboration with a physician or a physician assistant working under the supervision of a physician and providing care to the physician's patient panel need not have an independent patient panel; and

(B) In a practice where one or more residents provides care to patients, a community preceptor supervising a resident need not have an independent patient panel at the practice and need not have a primary affiliation with the practice, provided that: (i) The practice assigns all patients cared for by residents to the panel of an attending physician with a primary professional affiliation at the practice, (ii) all residents provide care under the supervision of a physician, (iii) the physician supervising the resident is the primary care provider whom the practice primarily identifies as performing the service pursuant to this subsection on claims and medical records and (iv) for all services provided by a resident, the practice clearly identifies in its medical records the resident, the supervising physician and the attending physician whose patient panel includes the patient; and

(4) Devote at least sixty percent of the primary care provider's total clinical time, across all payers and practice settings, to delivery of primary care services.

(d) At any time and on an ongoing basis, the department may monitor the performance of each practice with PCMH status and its compliance with all applicable standards and requirements. The department may deny, suspend or terminate the PCMH status of any practice that fails to comply with this section and may take any other action necessary to ensure compliance with all PCMH requirements. If the department denies, suspends or terminates a practice's PCMH status, the practice may request a review of such decision. The practice shall submit the request in writing to the department, together with any supporting documents, not later than fifteen days after receiving written notice of the denial, suspension or termination of PCMH status. The department shall issue a written decision not later than thirty days after receiving the practice's request. The practice's PCMH status shall not change until the department has issued its written decision on the request for review. There is no further right to review the department's decisions regarding PCMH status.

(e) Not less than twelve months before the expiration of its PCMH Level 2 or PCMH Level 3 recognition, each practice with PCMH status shall send the department a written description of the practice's plans to renew such recognition and comply with all PCMH requirements that will be in force for the renewal of such recognition. Upon request, the practice shall provide the department with any information or documents necessary to verify the practice's progress towards renewing its PCMH recognition. If requested by the practice, the department may provide technical assistance to a practice seeking to renew its PCMH recognition.

(f) Each practice that indicates its intent to renew its PCMH Level 2 or PCMH Level 3 recognition pursuant to subsection (e) of this section shall work diligently and in good faith to renew such PCMH recognition before it expires. If the department determines that the practice received and cooperated fully with technical assistance from the department and worked diligently and in good faith to renew its PCMH recognition before expiration but failed to obtain such renewal, the department may, in its sole discretion, for a period not to exceed nine months after the practice's PCMH recognition expires:

(1) Provide additional technical assistance to assist the practice in regaining PCMH Level 2 or PCMH Level 3 recognition in accordance with a written gap analysis and work plan developed by the practice in consultation with the department; and

(2) Notwithstanding the time limits contained in section 17b-262-929(e) of the Regulations of Connecticut State Agencies, reimburse the practice with non-performance-based Glide Path payments established pursuant to section 17b-262-932 of the Regulation of Connecticut State Agencies, provided that the practice continues to work diligently and cooperate with the department in good faith to obtain PCMH Level 2 or PCMH Level 3 recognition.

(NEW) Sec. 17b-262-929. Requirements for Glide Path Status

(a) Glide Path enables a practice not yet qualified, but seeking PCMH status to receive initial financial and technical assistance to assist the practice in qualifying for PCMH status. At the department's discretion, a practice may also receive technical assistance to prepare for submitting a Glide Path application.

(b) In order to qualify for Glide Path, a practice shall, at the time it submits its Glide Path application and on an ongoing basis:

(1) Be enrolled in CMAP with a valid provider enrollment agreement on file with the department and comply with all CMAP policies and procedures;

(2) Comply with all unique Glide Path billing requirements, as required by the department;

(3) Before submitting a Glide Path application: (A) complete an initial PCMH readiness evaluation process with the department and (B) submit a PCMH status application to the department;

(4) Submit a complete Glide Path application with all required documents and information not later than thirty days after submitting a PCMH status application to the

department;

(5) Participate in the department's primary care initiatives, as directed by the department;

(6) Demonstrate that it has initiated activities to achieve PCMH status by providing the department with its PCMH survey tool scores, a gap analysis illustrating the steps the practice will need to take to achieve a minimum of PCMH Level 2 recognition and a work plan documenting the steps the practice has taken and will take to achieve PCMH status within the Glide Path time limits in subsection (e) of this section, except that the department may, in its discretion, deem a non-standard practice to meet the requirements of this subdivision if the non-standard practice demonstrates that: (A) It provides care in accordance with a written schedule of service hours that it submits to the department for approval as part of its Glide Path application and resubmits to the department for re-approval not less than fourteen days before it proposes to change such schedule; (B) it is a satellite practice of a parent entity that the department approved for participation in Glide Path and maintains compliance with all Glide Path requirements; (C) it follows the same policies and procedures as the parent entity, including, but not limited to, using the same electronic health record system, if applicable, (D) on behalf of the non-standard practice, its parent entity will provide access to care or health care advice at one or more of the parent entity's full-service Glide Path practices, on days and hours when the non-standard practice does not provide care, seven days per week, twelve months per year; (E) it will diligently carry out plans to meet the department's PCMH status requirements in accordance with a gap analysis and work plan submitted to the department that it prepared in accordance with this subdivision, modified as necessary to apply to the non-standard practice; and (F) it will provide additional information in its claims for payment as required by the department;

(7) Provide the department with access to the practice's staff, facilities and documents involved in seeking PCMH status, including, but not limited to copies of reports, tools and other documents from the PCMH status standard-setting authority; and

(8) Comply with all written department policies, which the department shall publicize to all practices with Glide Path status and practices that have applied for such status before such policies take effect. The department shall post such policies on its website or by other means accessible to practices.

(c) Each Glide Path practice shall provide the department with a list of all primary care providers for whom it seeks Glide Path payments and shall send the department any changes to that list not more than thirty days after such change occurs. Each such primary care provider shall, at the time the practice submits its Glide Path application and on an ongoing basis, comply with subdivisions (1) to (4), inclusive, of section 17b-262-928(c) of the Regulations of Connecticut State Agencies.

(d) Glide Path Effective Date.

(1) The effective date of Glide Path is the first day of the month after the practice submits a complete Glide Path application to the department that complies with subsection (b) of this section, except that the effective date of Glide Path for a practice that submitted a complete Glide Path application on or before April 30, 2012 is the later of: (A) The

first day of the month prior to the month in which the practice submitted the application or (B) January 1, 2012.

(2) A practice shall not receive any Glide Path-related payments before the effective date of Glide Path status or any payments based on: (A) Claims with dates of service before the effective date of Glide Path status or (B) member enrollment months attributed to the practice before the effective date of Glide Path status.

(e) Glide Path Phases. The department shall establish and regularly update written policies for three consecutive phases of Glide Path. The department shall notify Glide Path practices and practices that applied for Glide Path status before any amended Glide Path policies take effect. The department shall post such policies on its website or by other means accessible to Glide Path practices.

(1) At the time of acceptance to Glide Path and on an ongoing basis, the department shall categorize each practice as Glide Path Phase 1, Phase 2 or Phase 3. A practice shall complete each Glide Path phase not later six months after beginning such phase, provided that the department may grant extensions of up to three months each, with a maximum of six months of total extensions throughout all Glide Path phases, following a written extension request by the practice submitted not less than thirty days before the expiration of the practice's current Glide Path phase. A practice shall complete Glide Path in not more than eighteen consecutive months, plus any approved extensions, and shall not be eligible for Glide Path payments after such period. A practice shall not receive Glide Path payments for a total of more than twenty-four months, including any time that the practice previously participated in Glide Path, except as provided in subparagraphs (A) and (B) of this subdivision.

(A) If the practice documents that extenuating circumstances deemed sufficient by the department prevented the practice from completing Glide Path within the twenty-four month period set forth in this subdivision, then the department may continue to provide technical assistance, Glide Path payments or both assistance and payments to the practice after the expiration of the twenty-four month period.

(B) A practice may receive assistance and payments pursuant to subparagraph (A) of this subdivision only (i) for a limited time established by the department and (ii) if the practice continues to work in good faith to attain PCMH status and diligently follows a written compliance plan established by the department.

(2) In order to qualify for each phase of Glide Path, a practice shall demonstrate that it met all requirements for all earlier phases, if applicable. A practice shall submit documentation of its compliance with the requirements for its current Glide Path phase not less than thirty days before the expiration of such phase, as extended by any approved extensions. If requested by the department, a practice shall also send the department ongoing reports, in a form established by the department, to document its progress in completing each Glide Path phase.

(f) In order to complete Glide Path Phase 3, a practice shall, not later than six months after completing Glide Path Phase 2, plus any approved extensions, obtain PCMH Level 2 or PCMH Level 3 recognition and send documentation of such recognition to the department.

(g) At any time and on an ongoing basis, the department may monitor each Glide Path practice's performance and compliance with all applicable standards and requirements. The department may deny, suspend or terminate the Glide Path status of any practice that fails to comply fully with this section and may take any other action necessary to ensure a practice complies with all Glide Path requirements, including, but not limited to requiring a practice to repeat a Glide Path phase. If the department denies, suspends or terminates a practice's Glide Path status, the practice may request a review of this decision. The practice shall submit the request in writing to the department, together with any supporting documents, not later than fifteen days after receiving written notice of the denial, suspension or termination of Glide Path status. The department shall issue a written decision not later than thirty days after receiving the practice's request. The practice's Glide Path status shall not change until the department has issued its decision on the request for review. There is no further right to review the department's decisions regarding Glide Path status.

(NEW) Sec. 17b-262-930. Requirements for PCMH Accreditation

(a) Eligible PCMH Accreditation Providers and Applicable PCMH Standards.

(1) FQHCs. An FQHC may seek PCMH accreditation to receive technical assistance from the department to attain and maintain PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition from the PCMH status standard-setting authority or PCMH certification from the PCMH accreditation standard-setting authority.

(2) Outpatient Hospital Clinics. An outpatient hospital clinic may seek PCMH accreditation to receive technical assistance from the department if it chooses to seek and maintain PCMH certification from the PCMH accreditation standard-setting authority in lieu of seeking and maintaining PCMH status pursuant to section 17b-262-928 of the Regulations of Connecticut State Agencies.

(b) A PCMH accreditation provider shall not receive any payments from the department based on PCMH accreditation, except that effective for the 2015 measurement year or later, the department may allow PCMH accreditation providers, or any subgroups thereof, to be eligible for performance-based supplemental payments pursuant to section 17b-262-933 of the Regulations of Connecticut State Agencies.

(c) A PCMH accreditation provider shall, at the time of its application and on an ongoing basis:

(1) Be enrolled in CMAP with a valid provider enrollment agreement on file with the department and comply with all CMAP policies and procedures;

(2) Participate in the department's primary care initiatives, as directed by the department;

(3) Complete an initial evaluation specified by the department before submitting an application for assistance from the department to attain PCMH accreditation;

(4) Submit a complete application to the department for assistance to attain PCMH accreditation that includes all required documents and information;

(5) In consultation with the department, prepare a gap analysis and work plan

documenting the steps that a PCMH accreditation provider has taken and will take to achieve, as applicable pursuant to subsection (a) of this section, PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition from the PCMH status standard-setting authority, except that the department may, in its discretion, deem a non-standard practice to meet the requirements of this subdivision if the non-standard practice demonstrates that: (A) It provides care in accordance with a written schedule of service hours that it submits to the department for approval as part of its PCMH accreditation application and resubmits to the department for re-approval not less than fourteen days before it proposes to change such schedule; (B) it is a satellite practice of a parent entity that is seeking PCMH accreditation in compliance with this subsection; (C) it follows the same policies and procedures as the parent entity, including, but not limited to, using the same electronic health record system; (D) on behalf of the non-standard practice, its parent entity will provide access to care or health care advice at one or more of the parent entity's full-service practices that is seeking PCMH accreditation in compliance with this subsection, on days and hours when the non-standard practice does not provide care, seven days per week, twelve months per year; and (E) it will provide additional information in its claims for data reporting purposes as required by the department; and

(6) Provide the department with access to the PCMH accreditation provider's staff, facilities and documents involved in seeking and maintaining PCMH accreditation, including, but not limited to copies of reports, tools and other documents from the PCMH status standard-setting authority or the PCMH accreditation standard-setting authority, as applicable.

(d) In order to obtain and maintain PCMH accreditation, a PCMH accreditation provider shall, at the time it submits its PCMH accreditation application and on an ongoing basis:

(1) Obtain and maintain PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition, as applicable pursuant to subsection (a) of this section, except that the department may, in its discretion, deem a non-standard practice to meet the requirements of this subdivision if the non-standard practice demonstrates that: (A) It provides care in accordance with a written schedule of service hours that it submits to the department for approval as part of its PCMH accreditation application and resubmits to the department for re-approval not less than fourteen days before it proposes to change such schedule; (B) it is a satellite practice of a parent entity that achieved and maintains (i) PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition and (ii) PCMH accreditation approval from the department pursuant to this section; (C) it follows the same policies and procedures as the parent entity, including, but not limited to, using the same electronic health record system; (D) on behalf of the non-standard practice, its parent entity will provide access to care or health care advice at one or more of the parent entity's full-service practices that achieved and maintains PCMH accreditation approval from the department, on days and hours when the non-standard practice does not provide care, seven days per week, twelve months per year; and it will provide additional information in its claims for data reporting purposes as required by the department;

(2) Comply with subdivisions (1), (2) and (6) of subsection (c) of this section;

(3) Use an electronic health record system for all patients treated within the PCMH accreditation provider and ensure that such records are available to, and shared by, all clinicians, as appropriate. Such system shall support both clinical and administrative functions including, but not limited to: Scheduling; treating patients; ordering services; prescribing; maintaining medical records; population management; and follow-up;

(4) Meet EPSDT services requirements, including, but not limited to: Timely comprehensive well visits, including hearing and vision screening; timely developmental screening; referral for preventive dental care for appropriate age groups; and referral for follow-up care based on conditions identified in well visits and inter-periodic visits and screenings;

(5) Adhere to consumer protections, including, but not limited to: Ensuring members' rights to confidentiality; nondiscrimination; timely access; informed choice; participation in treatment decisions; and access to a grievance process;

(6) Allow the department to include the FQHC or outpatient hospital clinic on lists of providers with PCMH accreditation available to members and referral sources; and

(7) Provide the department with any documents or information necessary to evaluate the quality of the PCMH accreditation provider's performance.

(e) Each PCMH accreditation provider shall provide the department with a list of all primary care providers who are primarily affiliated with the PCMH accreditation provider and shall send the department any changes to that list not more than thirty days after such change occurs. Each primary care provider for whom the PCMH accreditation provider seeks or maintains PCMH accreditation shall, at the time of the PCMH accreditation provider's application for PCMH accreditation and on an ongoing basis:

(1) Be enrolled with CMAP as an individual provider with a valid provider enrollment agreement on file with the department;

(2) Have a primary professional affiliation with the PCMH accreditation provider, except as provided in subdivision (3)(B) of this subsection;

(3) Function as a primary care provider and have a patient panel, except that:

(A) An APRN working in collaboration with a physician or a physician assistant working under the supervision of a physician and providing care to the physician's patient panel need not have an independent patient panel; and

(B) In a PCMH accreditation provider where one or more residents provides care to patients, a community preceptor supervising a resident need not have an independent patient panel at the PCMH accreditation provider and need not have a primary affiliation with the PCMH accreditation provider, provided that: (i) The PCMH accreditation provider assigns all patients cared for by residents to the panel of an attending physician with a primary professional affiliation at the PCMH accreditation provider, (ii) all residents provide care

under the supervision of a physician, (iii) the physician supervising the resident is the primary care provider whom the PCMH accreditation provider primarily identifies as performing the service pursuant to this subsection on claims and medical records and (iv) for all services provided by a resident, the PCMH accreditation provider clearly identifies in its medical records the resident, the supervising physician and the attending physician whose patient panel includes the patient; and

(4) Devote at least sixty percent of the primary care provider's total clinical time, across all payers and practice settings, to delivery of primary care services.

(f) The department shall provide technical assistance to each PCMH accreditation provider that is seeking PCMH accreditation. The department may also provide non-financial recognition and technical assistance to each PCMH accreditation provider that has achieved PCMH accreditation.

(g) At any time and on an ongoing basis, for each PCMH accreditation provider, the department may monitor the PCMH accreditation provider's performance and compliance with all applicable standards and requirements. The department may deny, suspend or terminate the PCMH accreditation of any PCMH accreditation provider that fails to comply fully with this section and may take any other action necessary to ensure the PCMH accreditation provider complies with all PCMH accreditation requirements. If the department denies, suspends or terminates a PCMH accreditation provider's PCMH accreditation, the PCMH accreditation provider may request a review of this decision. The PCMH accreditation provider shall submit the request in writing to the department, together with any supporting documents, not later than fifteen days after receiving written notice of the denial, suspension or termination of PCMH accreditation. The department shall issue a written decision not later than thirty days after receiving the PCMH accreditation provider's request. The status of such provider's PCMH accreditation shall not change until the department has issued its decision on the request for review. There is no further right to review the department's decisions regarding PCMH accreditation.

(NEW) Sec. 17b-262-931. Member Attribution to Practices with PCMH Status and Glide Path Status and PCMH Accreditation Providers

(a) The department shall attribute a member to a practice with PCMH status, a practice with Glide Path status or a PCMH accreditation provider based on the member's selection or visit history in accordance with the department's current written attribution procedures.

(b) The department shall periodically update a roster of members attributed to each practice with PCMH status, each practice with Glide Path status and each PCMH accreditation provider and shall provide each such practice and provider with its roster of members.

(NEW) Sec. 17b-262-932. Non-Performance-Based Payments for Practices with PCMH Status and Glide Path Status

(a) In addition to the fee-for-service payments, visit rates or other payment system that the department pays to each CMAP provider for providing services to members, a practice with PCMH status approved pursuant to section 17b-262-928 of the Regulations of Connecticut State Agencies or a practice with Glide Path status approved pursuant to section 17b-262-929

of the Regulations of Connecticut State Agencies is eligible for one of the two methods of non-performance-based payments described in subsections (c) and (d) of this section.

(b) During calendar years 2012 and 2013, the only method of non-performance-based PCMH and Glide Path payments is enhanced fee-for-service payments under subsection (c) of this section. On or after January 1, 2014, the department may select either enhanced fee-for-service payments pursuant to subsection (c) of this section or advance per member payments pursuant to subsection (d) of this section. The payment method within Glide Path and within each level of PCMH recognition shall be the same. The department shall notify practices with PCMH status and Glide Path status and practices that have applied for such status before changing the method of non-performance-based payments.

(c) Enhanced Fee-for-Service Payments. If the department has selected this payment method, also known as rate add-ons, the department may distribute enhanced payments, as determined by the department, for a subset of primary care services provided to members.

(1) The department shall make enhanced fee-for-service payments to a practice as enhancements to the current Medicaid fee schedule, visit rate or other fee applicable to the practice. The department shall post the primary care codes for which enhanced fee-for-service payments are available on its website or by other means accessible to providers.

(2) Each practice with PCMH status or Glide Path status seeking enhanced fee-for-service payments under this subsection shall submit all information required by the department to process each claim, including, but not limited to: Any form necessary to submit a claim for a visit rate, if applicable; all relevant CPT codes; and all relevant ICD diagnostic codes. Practices paid using a visit rate or other similar single encounter fee shall provide the department such additional information with each applicable claim as necessary for the department to determine the subset of primary care services provided during each visit or encounter for which the practice seeks enhanced fee-for-service payments.

(d) Advance Per Member Payments. If the department has selected this payment method, the department may distribute monthly or quarterly payments to practices with PCMH status and Glide Path status calculated by multiplying a set per member per month or per member per quarter rate, as applicable, by the number of members attributed to the practice in accordance with section 17b-262-931(a) of the Regulations of Connecticut State Agencies.

(e) The department may vary the applicable non-performance-based payment rate based on a variety of factors, including, but not limited to: (A) Whether the practice has PCMH status or Glide Path status, (B) the practice's provider type, (C) whether a practice with PCMH status has PCMH Level 2 or PCMH Level 3 recognition, (D) measures of members' health risks or (E) any combination of such factors.

(NEW) Sec. 17b-262-933. Performance-Based Supplemental Payments

(a) The department may distribute performance-based supplemental payments to each practice with PCMH status approved pursuant to section 17b-262-928 of the Regulations of Connecticut State Agencies. The department, in its discretion, may also distribute performance-based supplemental payments pursuant to this section to any subgroups or

combinations of the following additional groups of providers: (1) practices with Glide Path status or (2) PCMH accreditation providers. In order to be eligible for such payments, each practice or, if applicable, PCMH accreditation provider, shall comply with all requirements for performance-based supplemental payments. The department shall make such payments in an annual lump sum not later than six months after the close of the measurement year. The department shall calculate the payments by multiplying the monthly payment rate for the practice or, if applicable, PCMH accreditation provider, established by the department pursuant to this section by the number of months that the department attributes each member to the practice pursuant to section 17b-262-931(a) of the Regulations of Connecticut State Agencies.

(b) The department shall establish and update the quality measures for performance-based supplemental payments, which may differ between practices with different levels of PCMH status and if applicable, between practices with Glide Path status and PCMH accreditation providers. The department shall notify all practices with PCMH or Glide Path status, practices that applied for such status and PCMH accreditation providers, if applicable, before the quality measures or any revisions take effect. The department shall post the quality measures on its website or by other means accessible to practices with PCMH or Glide Path status and if applicable, PCMH accreditation providers. Each practice and each PCMH accreditation provider shall report all performance data specified by the department in a form and manner determined by the department.

(c) Using a written methodology, the department shall evaluate each practice's performance and each PCMH accreditation provider's performance during the measurement year using the quality measures applicable to the practice. The department's performance-based supplemental payment rate schedule may set different rates based on a practice's or provider's level of performance or improvement, as applicable.

(d) The department may distribute the following types of performance-based supplemental payments to eligible practices or, if applicable, PCMH accreditation providers:

(1) Performance Incentive Supplemental Payment. Each year, the department shall calculate each practice's performance incentive supplemental payment rate on the payment schedule based on the practice's performance during the measurement year compared to all practices with PCMH status, all practices with Glide Path status, all PCMH accreditation providers, if applicable, or any combination of those groups of providers. The department may distribute a performance incentive supplemental payment only to a practice or, if applicable, a PCMH accreditation provider, that (A) continuously maintained PCMH status or Glide Path status or continuously met the requirements for seeking or maintaining PCMH accreditation, as applicable, in good standing for all twelve months of the measurement year and (B) performed in the twenty-fifth (25^{th}) to one-hundredth (100^{th}) percentiles, inclusive, during the measurement year.

(2) Performance Improvement Supplemental Payment. Each year, the department shall calculate each practice's or, if applicable, each PCMH accreditation provider's performance improvement supplemental payment rate on the payment schedule based on the practice's or provider's performance during the measurement year compared to the calendar year prior to the measurement year. After each measurement year, the department shall develop performance improvement targets necessary for practices or

providers to be eligible to receive performance improvement supplemental payments. A practice or, if applicable, PCMH accreditation provider, that performs in the ninety-first (91st) to one-hundredth (100th) percentiles, inclusive, during the measurement year may be eligible for a performance improvement supplemental payment even if the practice's or provider's performance did not improve compared to the calendar year prior to the measurement year. The department may distribute a performance improvement supplemental payment only to a practice or, if applicable, PCMH accreditation provider, that continuously maintained PCMH status or Glide Path status or continuously met the requirements for seeking or maintaining PCMH accreditation, as applicable, in good standing for all twelve (12) months of the measurement year and the calendar year prior to the measurement year.

(e) Review of Performance-Based Supplemental Payments. If a practice with PCMH status or Glide Path status or PCMH accreditation provider, if applicable, did not qualify for a performance-based supplemental payment or for the full amount of such payment, the practice or provider may request a review from the department. The practice or provider shall submit the request in writing to the department, together with any supporting documents, not later than fifteen days after receiving the performance-based supplemental payment determination letter. After review by staff not previously involved in the decision, the department shall issue a written decision not later than fifteen days after receiving the request for review. There is no further right to review the department's decisions regarding performance-based supplemental payments.

(NEW) Sec. 17b-262-934. Documentation and Record Retention Requirements

(a) Each provider shall maintain a specific record for all services provided to each member including, but not limited to: Name, address, birth date, CMAP identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the provider, documentation of services provided and the dates services were provided.

(b) Each provider shall maintain all required documentation in its original form for at least five years or longer as required by applicable statutes and regulations, subject to the department's review. If there is a dispute concerning a service provided, the provider shall maintain the relevant documentation until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(c) The department may disallow and recover any amounts paid or pending to the provider for which required documentation is not maintained or not provided to the department upon request. The department may access and audit all relevant records and documentation and take any other appropriate quality assurance measures necessary to assure compliance with all regulatory and statutory requirements.

(NEW) Sec. 17b-262-935. Reserved

(NEW) Sec. 17b-262-936. Reserved

Statement of Purpose

Pursuant to CGS Section 4-170(b)(3), "Each proposed regulation shall have a statement of its purpose following the final section of the regulation." Enter the statement here.

These regulations establish rules for providers who seek to participate in the Person-Centered Medical Home (PCMH) program. Eligible practices that demonstrate a higher standard of person-centered primary care may qualify for technical assistance, enhanced payments and performance-based supplemental payments. Through the Glide Path option, practices not yet qualified for PCMH status may be eligible for financial and technical assistance to make improvements necessary to achieve PCMH status. Through the PCMH accreditation option, FQHCs (and hospital outpatient clinics choosing to seek The Joint Commission PCMH certification rather than NCQA PCMH recognition) may be eligible for non-financial technical assistance to achieve NQCA PCMH recognition or The Joint Commission PCMH certification, as applicable.

(A) The problems, issues or circumstances that the regulation proposes to address: The PCMH program is one of several healthcare reforms introduced by the department as part of the transition of CMAP to an entirely fee-for-service model administered by an administrative services organization, effective January 1, 2012. The purpose of the PCMH program is to encourage primary care providers to deliver a higher standard of primary care and expand access and quality of care provided to members.

(B) The main provisions of the regulation: (1) establish PCMH status, Glide Path, and PCMH accreditation provider participation requirements; (2) describe non-performance-based payment requirements and procedures; and (3) describe performance-based supplemental payment requirements and procedures.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation establishes requirements for enhanced primary care delivery and related payment methods for providers that choose to participate in the PCMH program.

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(Certification page—see Instructions on back)

CERTIFICATION

This certification statement must be completed in full, including items 3 and 4, if they are applicable.

1) I hereby certify that the above *(check one)* ☒ Regulations ☐ Emergency Regulations

2) **are** *(check all that apply)* ☒ adopted ☐ amended ☐ repealed **by this agency pursuant to the following authority(ies):** *(complete all that apply)*

a. Connecticut General Statutes section(s) 17b-3, 17b-262 and 17b-263c.

b. Public Act Number(s) _____.
(Provide public act number(s) if the act has not yet been codified in the Connecticut General Statutes.)

3) And I further certify that notice of intent to adopt, amend or repeal said regulations was published in the *Connecticut Law Journal* on January 17, 2012;
(Insert date of notice publication if publication was required by CGS Section 4-168.)

4) And that a public hearing regarding the proposed regulations was held on n/a;
(Insert date(s) of public hearing(s) held pursuant to CGS Section 4-168(a)(7), if any, or pursuant to other applicable statute.)

5) **And that said regulations are EFFECTIVE** *(check one, and complete as applicable)*

☒ When filed with the Secretary of the State

OR ☐ on *(insert date)* _____

DATE	**SIGNED** ***(Head of Board, Agency or Commission)***	OFFICIAL TITLE, DULY AUTHORIZED
[TBD]		Commissioner

APPROVED *by the* ***Attorney General*** *as to legal sufficiency in accordance with CGS Section 4-169, as amended*

DATE	SIGNED *(Attorney General or AG's designated representative)*	OFFICIAL TITLE, DULY AUTHORIZED

Proposed regulations are ***DEEMED APPROVED*** *by the Attorney General in accordance with CGS Section 4-169, as amended, if the attorney General fails to give notice to the agency of any legal insufficiency within thirty (30) days of the receipt of the proposed regulation.*

(For Regulation Review Committee Use ONLY)

☐ Approved ☐ Rejected without prejudice

☐ Approved with technical corrections ☐ Disapproved in part, *(Indicate Section Numbers disapproved only)*

☐ Deemed approved pursuant to CGS Section 4-170(c)

By the Legislative Regulation Review Committee in accordance with CGS Section 4-170, as amended	DATE	SIGNED *(Administrator, Legislative Regulation Review Committee)*

Two certified copies received and filed and one such copy forwarded to the Commission on Official Legal Publications in accordance with CGS Section 4-172, as amended.

DATE	SIGNED *(Secretary of the State)*	BY

(For Secretary of the State Use ONLY)

R-39 Rev. 02/2012
(Instructions page)

GENERAL INSTRUCTIONS

1. All regulations proposed for adoption, amendment or repeal, *except* emergency regulations, must be presented to the Attorney General for his/her determination of legal sufficiency. (See CGS Section 4-169.)

2. After approval by the Attorney General, the original and one electronic copy (in Word format) of all regulations proposed for adoption, amendment or repeal must be presented to the Legislative Regulation Review Committee for its action. (See CGS Sections 4-168 and 4-170 as amended by Public Act 11-150, Sections 18 and 19.)

3. Each proposed regulation section must include the appropriate regulation section number and a section heading. (See CGS Section 4-172.)

4. New language added to an existing regulation must be in underlining or CAPITAL LETTERS, as determined by the Regulation Review Committee. (See CGS 4-170(b).)

5. Existing language to be deleted must be enclosed in brackets [ ]. (See CGS 4-170(b).)

6. A completely new regulation or a new section of an existing regulation must be preceded by the word "(NEW)" in capital letters. (See CGS Section 4-170(b).)

7. The proposed regulation must have a statement of its purpose following the final section of the regulation. (See CGS Section 4-170(b).)

8. The Certification Statement portion of the form must be completed, including all applicable information regarding *Connecticut Law Journal* notice publication date(s) and public hearing(s). (See more specific instructions below.)

9. Additional information regarding rules and procedures of the Legislative Regulation Review Committee can be found on the Committee's web site: http://www.cga.ct.gov/rr/ .

10. A copy of the Legislative Commissioners' Regulations Drafting Manual is located on the LCO website at http://www.cga.ct.gov/lco/pdfs/Regulations_Drafting_Manual.pdf.

CERTIFICATION STATEMENT INSTRUCTIONS
(Numbers below correspond to the numbered sections of the statement)

1. Indicate whether the regulation is a regular or an emergency regulation adopted under the provisions of CGS Section 4-168(f).

2. a) Indicate whether the regulations contains newly adopted sections, amendments to existing sections, and/or repeals existing sections. Check all cases that apply.

   b) Indicate the specific legal authority that authorizes or requires adoption, amendment or repeal of the regulation. If the relevant public act has been codified in the most current biennial edition of the *Connecticut General Statutes*, indicate the relevant statute number(s) instead of the public act number. If the public act has not yet been codified, indicate the relevant public act number.

3. Except for emergency regulations adopted under CGS 4-168(f), and technical amendments to an existing regulation adopted under CGS 4-168(g), an agency must publish notice of its intent to adopt a regulation in the *Connecticut Law Journal*. Enter the date of notice publication.

4. CGS Section 4-168(a)(7) prescribes requirements for the holding of an agency public hearing regarding proposed regulations. Enter the date(s) of the hearing(s) held under that section, if any; also enter the date(s) of any hearing(s) the agency was required to hold under the provisions of any other law.

5. As applicable, enter the effective date of the regulation here, or indicate that it is effective upon filing with the Secretary of the State. Please note the information below.

   Regulations are effective upon filing with the Secretary of the State or at a later specified date. See CGS Section 4-172(b) which provides that each regulation is effective upon filing, or, if a later date is required by statute or specified in the regulation, the later date is the effective date. An effective date may not precede the effective date of the public act requiring or permitting the regulation. Emergency regulations are effective immediately upon filing with the Secretary of the State, or at a stated date less than twenty days thereafter.